

GYNECOLOGY

UNDER THE CHARGE OF

JOHN G. CLARK, M.D.,

PROFESSOR OF GYNECOLOGY IN THE UNIVERSITY OF PENNSYLVANIA, PHILADELPHIA.

Division of Ureter in Pelvic Operations.—When a ureter has been accidentally cut in the course of a pelvic operation, the surgeon usually has a choice of several procedures in considering the best method of repairing the damage. According to GRAVES (*Boston Med. and Surg. Jour.*, 1917, clxxvi, 149) ligating the ureter has certain advantages over anastomosis and implantation. It requires very little expenditure of time, usually an important consideration, as the operations in which the ureter is cut are generally of great severity. If the end of the ureter is properly tied, there is little danger of leakage and fistula. Hydronephrosis will occur in 80 per cent. of cases but it is not great and gradually subsides as the kidney atrophies. If a dangerous hydronephrosis should occur, the kidney may be removed at a later operation. Anuria appears in about 1.6 per cent. of cases after ligation of one ureter. It is highly probable that ureteral anastomosis is more commonly followed by fistula formation and infection than is the ligature operation. Furthermore, it is evident from the literature that most of the cases of death following ligature of the ureter have been due to shock following some extremely severe operation rather than to the closure of the ureter. Graves prefers an anastomosis to an implantation, since by the former only one organ is injured, and if a fistula or pyelonephritis ensues, the kidney may be removed and the trouble cured by one operation. On the other hand, if a fistula follows implantation of the ureter into the bladder, the surgeon then has to deal with two injured organs. The operation for reimplantation or closure of a ureterovesical fistula is, in Graves's opinion, less satisfactory than a simple nephrectomy, such as might be necessitated by trouble from ligature or anastomosis. If implantation is imperative, as might be the case in the presence of injury of the other ureter, or a functional deficiency or disease of the opposite kidney, the location of choice for implantation would be, of course, in the bladder, if the proximal end of the ureter is sufficiently long. In case of emergency the ureter may be left to drain from the vagina or carried out through the skin. Implantation into the intestine is not desirable on account of the almost inevitable ascending infection of the kidney. Implantation into the appendix or of one ureter into the other or even into the Fallopian tube are operations that have been advocated from experiments on animals and on the cadaver but probably have no practical value.

Treatment of Ectopic Gestation.—Contrary to the views of many, immediate deaths as a result of hemorrhage in cases of ectopic pregnancy were rare in WERDER's experience (*West Virginia Med. Jour.*, 1917, xi, 233) in a series of over 200 cases. There is a strong tendency in most cases for the bleeding to become checked spontaneously, especially under proper treatment, but persistent watching is required on

account of the constant danger of recurring hemorrhage. Shock is often an important factor, the elimination of which should be undertaken before operation when possible, thereby reducing the operative risk. Delay of operation is therefore generally advisable in grave cases after rupture, particularly when bleeding seems to be at least under temporary control. This will enable us to overcome the attending shock and also to gain the additional advantage of an improved circulation through the refilling of the depleted bloodvessels, advantages which will greatly minimize the risks attending the operative treatment.

The treatment of that rare but interesting form of extra-uterine pregnancy in which fetal life escapes destruction at the time the tragic symptoms occur, and continues to develop until the fetus has reached a viable age, presents some interesting features. The greatest difficulty and source of danger in this condition is the placenta, since the hemorrhage encountered in the removal of the living placenta is truly frightful and frequently fatal. Nevertheless, Werder believes that the only rational treatment is the entire removal of the placenta and sac, which can be done without undue hemorrhage if the uterine and ovarian arteries are controlled before the removal is begun. When these arteries are not accessible we may resort to compression of the abdominal aorta, by which means we can temporarily, at least, control hemorrhage until the placenta is out of the way and its principal blood supply is secured.

After-results of the Interposition Operation.—AYRES (*Am. Jour. Obst.*, 1917, lxxvi, 451) has had the opportunity of examining 37 patients upon whom the interposition operation had been performed, the examination including a cystoscopic study as well as a vaginal examination in nearly every case. Of the entire series, only 16 patients were free from some undesirable symptom, although in many cases the trouble was insignificant. An analysis of the 21 cases that presented undesirable symptoms shows that cystitis was complained of in 9 cases, prolapse of the fundus in 4 cases, recurrence of the cystocele in 2 cases, incontinence in 3 cases, persistent bleeding in 2 cases and separation of the anterior vaginal wall in 1 case. Considered from an anatomical result the appearances are better, since 30 of the 37 patients could be said to have a perfect cure of cystocele, rectocele and prolapse. One very significant fact is that out of the total of 21 unfavorable cases, 11 occurred in patients operated upon for complete prolapse. Out of the 9 cases of cystitis, 5 occurred in such individuals, while all the cases that had poor anatomical results occurred in those operated upon for complete prolapse. Ayres has analyzed the results in this series and has drawn certain conclusions in regard to the indications for the interposition operation. Obviously it is an unwise procedure during the child-bearing age and likewise is contra-indicated in cases of prolapse of the third degree, but may be used to advantage in the lesser degrees of prolapse with cystocele. When fibroids are present or a condition of fibrosis is suspected, denoted by profuse, irregular bleeding, hysterectomy should be performed and the other indications met. When the operation is indicated, large uteri should be reduced in size in the course of the operation and an effort be made to keep the bladder floor level; furthermore, one should not hope to cure incontinence without strengthening the sphincter of the bladder.